Centers for Medicare & Medicaid Services
Special Open Door Forum:
Electronic Prescribing
Wednesday, November 19, 2008
3:30pm-5pm ET
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) is hosting this Special Open Door Forum (ODF) on Electronic Prescribing (E-Prescribing). CMS staff will present information on the following topics: Overview of Part D E-Prescribing Standards, E-Prescribing Resources, E-Prescribing Incentives and E-Prescribing Measures.

Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorizes a new and separate incentive program for eligible professionals who are successful electronic prescribers (e-Prescribers) as defined by MIPPA. This new incentive program removes the e-prescribing measure from the Physician Quality Reporting Initiative (PQRI) for 2009.

For more updated information about E-Prescribing, please visit: http://www.cms.hhs.gov/EPrescribing/ and visit the E-Prescribing Incentive Program webpage http://www.cms.hhs.gov/PQRI/03_EPrescribingIncentiveProgram.asp#TopOfPage

We look forward to your participation.

Open Door Forum Instructions**:**

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An audio recording of this Special Forum will be posted to the Special ODF website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning December 1, 2008 and available for 30 days.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at: http://www.cms.hhs.gov/OpenDoorForums/

Thank you.

Centers for Medicare & Medicaid Services
Agenda
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Welcome & Introduction of Presenters
-Natalie Highsmith, Office of External Affairs (OEA)

Overview of Part D E-Prescribing Standards
-Andrew Morgan, Office of E-Health Standards & Services (OESS)

E-Prescribing Resources
-Andrew Morgan (OESS)

E-Prescribing Incentives
-Dr. Michael Rapp, Office of Clinical Standards & Quality (OCSQ)

E-Prescribing Measure #125
-Dr. Daniel Green (OCSQ)

Consumer Support- AARP Research Findings
-Paul Cotton, AARP

Open Q&A

Closing Remarks

Audio File for this Transcript: http://media.cms.hhs.gov/audio/SpcODFPtD_ePrescribing.mp3

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Special Open Door Forum on Part D ePrescribing

Moderator: Natalie Highsmith
Conference Leader: Andrew Morgan

November 19, 2008
3:30 pm ET

Operator: Good afternoon. My name is (Laurie) and I will be your conference facilitator today.

At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum on Electronic Prescribing.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star, then the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key.

At this time, I will turn the conference over to Ms. (Natalie Highsmith).

Please go ahead, Ms. (Highsmith).

(Natalie Highsmith): Thank you, (Laurie). And good day to everyone and thank you for joining us for the Special Open Door Forum on Electronic Prescribing.

Section 132 of the Medicare Improvements for Patients and Providers Act of 2008, also known as MIPPA, authorizes a new and separative incentive payment program for eligible - I'm sorry, a separate incentive program for eligible professionals who are successful electronic prescribers, also known as E-Prescribing, as defined by MIPPA.

Today, CMS staffs will present information on the following topics: overview of Part D E-Prescribing standards, E-Prescribing resources, E-Prescribing incentives and E-Prescribing measures.

The agenda for today's special open door has been posted on the Special Open Door Forum Web page. You can go to www.cms.hhs.gov/opendoorforums.

On the left-hand side, you will see a link for Special Open Door Forums. You click on that link and it will be in the download section identified by today's date and the topics.

I will now turn the call over to for our first agenda item, which is the overview of Part D E-Prescribing standards to (Andrew Morgan), who works in our office of E-Health Standards and Services.

(Andrew)?

(Andrew Morgan): (Natalie), good afternoon everybody.

I just want to go over one of the timelines of how CMS got into E-Prescribing and some of the standards that we have adopted over the last couple of years.

The Medicare Prescription Drug, Improvement Act - and Modernization Act of 2003 mandated the adoption of standards for our time transition for prescriptions and certain other information for covered drugs, prescribed on a Medicare Part D program.

While this requirement is voluntary for physicians and doctors to participate, what they do participate in can be prescribed by proxy, they must comply with adoptive standards. Prescription drug plans, PDP pharmacists, Medicare, advantage organizations offering Medicare advantage prescription drug plan and other Part D sponsors.

However they must report and comply with the standards that have been adopted.

On November 7, 2005, CMS published foundations standards that became effective on January 1, 2006. These standards apply to all electronic prescribing done under Part D of MMA.

The foundation standards which (unintelligible) foundation standards (unintelligible) into that building block for understanding that we may adopt in the future and as you will see, we have adopted more this year.

The first foundation standard was the MC-PDP script version 5.0 transactions. This transaction happens between prescribers and dispensers for new prescriptions, refills, change, (unintelligible) and messaging that the standard that carries this electronic prescription from the physician to pharmacy.

We also adopted the (ASTX12) 270/271 version (40.10). This is the eligibility benefits inquiry in the responses between prescribers and Part D sponsors.

And we also adopted the (EMC PDP) telecommunication standards version 5.1, which is the eligibility and benefits that require responsive between dispensers and Part D sponsors.

It is also important to note that this last (unintelligible) that I mentioned are off the HIPPA transaction standards.

MMA required CMS to implement (unintelligible) project to test additional standards in 2006. These initial standards that were pilot tested for benefit information transactions, electronic prior authorization, medication history transactions, and structured (unintelligible) in our (unintelligible).

As a result of the pilot test we announced in a report to Congress on April 2007 the basis for an MPRS, proposing additional standards that was published on November 15, 2007.

(Finally) E-Prescribing was published at the Federal Register on April 7, 2008. The final rules provide adopted the following initial standards to be implemented by 2009.

In that final rule, we retired the scripts standard version 5.0 and we implemented version 8.1, which is an updated version on script statement.

And also adopted (formulary) benefits. The (formulary) benefits transaction displaced drug (formulary) status on (formulary) - for all

(formulary) drugs. It also displays alternative drugs, copays and other standard information for beneficiary prescription plans.

We also adopted medication history to that program.

This provides prescribers with information about medications and a beneficiary they are already taking, including those prescribed by the providers to help reduce the number of adverse drug effects.

They also adopted (refill) status notification. This allows (unintelligible) electronic notice (unintelligible) telling him that a patient's prescription has been picked up. It's not picked up or has been partially filled.

This is to help monitor medication adherence in patients with chronic conditions.

We also adopted the national provider identifier (unintelligible). It was used at the individual level as the identifier (prescribing to) Medicare Part D. The individual level identifier will assist pharmacy to identify which prescribers (unintelligible) the electronic prescription cases where clarification were requested (unintelligible) presents someone a script.

With that, I would like to point you to some resources that you can further (unintelligible) on the Web. If you like to learn more about the E-Prescribing standards for Part D, you can go to the prescribing page at cms.hhs.gov/eprescribing.

Also there is some good tools that the E-Health initiative has recently published (unintelligible) the client is that www.ehealthinitiative.org/

(unintelligible) rx (unintelligible) there you will find series of guidance (unintelligible) issue over the last four months (unintelligible) to support the effective adoption of E-Prescribing.

Some of those reports are a clinician's guide to electronic prescribing, a consumer's guide to electronic prescribing, and electronic prescribing (unintelligible).

(Mike Rapp): Thank you, (Drew).

You have just heard (Drew) go over the Part D standards which demonstrated the interest in electronic prescribing going back to the Medicare Modernization Act.

And what I'm going to do now is to (focus) on the electronic prescribing incentive program that was authorized by the recent legislation.

MIPPA legislation was enacted in July of 2008. And part of that I'll refer to the measurement and how that's going to work for the electronic prescribing incentive program and then Dr. (Green) will, after that, go into a bit more detail and on the (measuring), perhaps repeat some of the things that I'm going to say.

But I think some of these bear repetition because we want to make sure people are clear on how the program works.

So just in general, what electronic prescribing is, it has been defined in some of our regulations is the transmission using electronic media of prescription of prescription related information between prescriber, dispenser, pharmacy benefit manager or health plan, either directly or

through an intermediary including in E-Prescribing network but it does include but it's not limited to two-way transmissions between the point of care in the dispenser.

There have been many potential benefits to electronic prescribing that have been postulated, including safety, efficiency, formulary adherence, drug surveillance and cost savings.

But to date there's been somewhat limited adoption of electronic prescribing by professionals. It's been estimated. There are various estimates on how frequent electronic prescribing is used but the estimates range between 5% and 18% of prescribers actually electronically prescribing.

And as we've been discussing, the Medicare Modernization Act and the Medicare Prescription Drug Benefit Program promoted the use of electronic prescribing by requiring the adoption of interoperable Part D standards through electronically prescribing Part D covered drugs, prescribed to Part D eligible individuals.

So as (Drew) mentioned, there's - their requirement is so that if electronic prescribing is used within Part D, then the standards that have been adopted need to be used as part of that prescribing.

The way electronic prescribing generally works is an eligible professional decides to order prescription for the patient, enters the prescription into electronic prescribing program and then transmits it to the desired pharmacy and the communications can also occur between the pharmacy benefit manager and the physician. So there are three parts to communication that's going on between the professional, the pharmacy and the pharmacy benefit manager.

So with that just general background, there - the Congress demonstrated a clear interest in promoting and incentivizing the use of electronic prescribing in the MIPPA legislation by providing an incentive program for eligible professionals who would do this.

And I'm going to go through what that means.

So until recently, we were able to only reflect on this somewhat generally because the specifics of how the incentive program would work were we wait until they were published in the physician fee schedule rule on November 1.

So that date has come and gone and the details have been published. So in addition to the information that you're hearing on this call today I will give you a Web site link later but you can -- on the CMS Web site -- go to the physician fee schedule final rule.

In there you'll see a fairly detailed discussion, actually more information that we typically provide in terms of detail in a rule and goes beyond the actual necessity for the rulemaking, but it provides a lot of, I think, detailed information that this is a new program. We - it was important to make sure people could understand it.

And so as I said, there's a lot of detailed information that's in the rule itself. It is a some 1600-page document, I think. So fortunately this only is a relatively small part of it I think maybe 20 pages or so.

So if you look through the rule you'll find that section on electronic prescribing and then, you know, I think you'll find it's helpful.

But basically the way the incentive works and what MIPPA provided for is that, in addition, the MIPPA, first of all, dealt with the physician quality reporting initiative, which is something that's been going on for the last couple of years.

And (unintelligible) that program permanent but the 2% incentive payment for 2009 and 2010 for physicians and other eligible professionals that would report quality measures as stipulated under the program.

But in addition to that, the Congress provided that there would be a 2% incentive program for eligible professionals who were - who qualified as successful electronic prescribers.

So specifically for 2009 and 2010 each year, the eligible professional who fits into this definition can achieve an incentive payment of 2% of all Part B allowed charges if, again, a successful electronic prescribed.

So each of 2009 and 2010 and 2011 and 12, there's ability for each of those years to get 1% of all allowed Part D charges and 2013, 0.5%.

Two-thousand-and-fourteen, no more incentive exists and unlike (PQRI), there is in the electronic prescriber program a parallel future fee reduction penalty that would start in 2012 1%, 2013 1-1/2% and 2014 and beyond 2%.

So again, an incentive is available through successful electronic prescribers for 2009 through 2013, a penalty will apply for those who do - for certain professionals who do not electronically prescribe starting in 2012.

Basically you'll see that the differential is 2% overall starting with the 2% positive in 2009, 2010 and 2% negative for 2014 and beyond.

Now the fee reduction will be prospective. So the way this physician quality reporting initiative works is when qualifies during a particular reporting period and then receives an incentive payment the next year.

So in the (PQRI) for example, we recently in the summer made the payments, the incentive bonus payments for (PQRI) for 2007. So in 2008 we made a bonus payment based upon (qualifying) in 2007.

In 2000 - we're collecting data currently in 2008 and we'll make a bonus payment for (PQRI) in 2009.

In 2009 in (PQRI) and electronic prescribing, those are that are successful in each - in one or more of those, the incentive payment will be made in mid-year 2010.

The penalty can't very well do a retrospective penalty. So the way Congress set that up is the fee reduction will be prospective.

So based upon - the penalty will start in 2012. So we will need to set forth in the future rulemaking how that will work but essentially for some reporting period prior to 2012, a determination will be made as to the applicability of a fee reduction in 2012.

So in effect one can both earn and incentive and avoid a penalty in the same year. That reporting period which will be the relevant reporting period has not been determined. Statute prevents it from being before 2010, so it definitely won't be 2009. It could be 2010, 2011, or some part thereof.

So it would be possible for example, that for the first half of 2011, if one did not successfully in electronically prescribe, then a penalty would apply in 2012.

Again, that is something that will be delineated in the future and that we would expect to make some - we would expect that the secretary would make some provision for this in the next years physician fee schedule rule.

In the MIPPA legislation of what is (successful) electronic prescribers set forth that we delineated that in more detail in a physician fee schedule rule this year.

And specifically that it references an existing measure in the physician quality reporting initiative that measure is identified as measure number 125 and I want - the only significance of that number is that all (PQRI) measures have specific individual numbers once that number is applied to that measure, numbers only used for that individual retire the number for all purposes that we - if we were to retire the measure, we wouldn't use that number again.

But this happens to be the structural measure that we developed and put in to the 2008 (PQRI), it's numbered number 125.

And under the MIPPA legislation is what the incentive program for electronic prescribing is based upon.

So we've been pointing people to that particular measure so that they can get a sense of how it would work in 2009 and have - given the caveat, of course, that that measure although it forms the basis for the

electronic prescribing incentive in 2009, the exact specifications for the measure were subject to modification. And they still are for that matter through December 31, 2009.

But nevertheless, so we have narrowed down the amount of modification that might be made which I'll discuss a bit more in the future and we think insofar as some additional modifications may be made to the measure, they'll be quite technical.

It would be limited likely to possibly removing certain of the codes in the denominator. But beyond that, one what we expect any significant changes to the measure.

And Dr. (Green) will go into some more detail about the - how the measure itself works.

In the (PQRI) for 2008, although the electronic prescribing measure was in there, it was one of another 118 measures and they could be used to qualify for the (PQRI) incentive payment requiring an 80% reporting rate. That's not what's required for the successful electronic prescriber for 2009.

The way that - but basically, it is the same type of reporting mechanism as we have for (PQRI). It's a claims based reporting system and requires based upon a reporting denominator for the eligible professional to report a reporting numerator code one of three specific codes.

And if one reports those codes - one of those codes in the applicable cases, 50% of the time, then one meets the statutory definition of a successful electronic prescriber.

Once one meets the definition, qualifies a successful electronic prescriber, then the incentive payment is 2% of all allowed Part D charges for that practitioner.

In other words, it's not limited to those patients for which one electronically prescribed is not even limited to those patients for which the measure is reported.

The qualification for a successful electronic prescriber depends upon that, but the incentive itself is total Part B allowed charges, which in general will be substantially broader scope of charges than those for which measure might be reported.

What is an eligible professional? It's the same basic definition as under PQRI. Its physicians but a broad range of other professionals, nurse practitioners, and others but of course since this is an electronic prescriber incentive program, you would be limited to professionals with prescribing authority because one obviously can't electronically prescribe if they don't have authority to prescribe it all.

And so the successful reporters, one that successfully reports on the measure, and that requires, as I mentioned, 50% of applicable cases. We implemented this in the 2009 physician fee schedule rules, which I've mentioned previously.

There's a couple of basic things to keep in mind. We're going to be going over it again in some detail how the incentive program works.

But in addition to understanding the details of the incentive structure or the measure, there's an overall requirement to report electronic

prescribing measure and that is this: That one has to have an electronic prescribing system. One has to have adopted a qualified E-Prescribing system and have that available.

If one does not have a qualified electronic prescribing, there is nothing to report on the measure. And so the way that works out since there's a requirement from 50% reporting of applicable cases, it's conceivable that a person may not have the electronic prescribing system on January 1.

Well the clock starts ticking January 1, but assuming that one could conceivably wait till April 1 to start and get the system and start reporting, in that case, one would have to report on 75% of their cases to meet the 50% overall assuming an even distribution of cases or if one waited until July and one could possibly report on 100% of their cases and still meet 50% through the whole year.

But just as important is figuring out how the measure works and how one will report that. It's important to focus since we're already in mid-November, if one doesn't have an electronic prescribing program to think in terms of getting one and which one would that be.

And I'll make a few comments about that.

The electronic prescribing measures I mentioned is a claims based measure. It has two basic components to it: a reporting denominator and a reporting numerator.

And the reporting denominator is one - it's certain codes which are generally office visit codes. Those normal codes that one would bill

such as (E&M) service in the office and a variety of others that Dr. (Green) will tell you more specifically about.

But what puts one in the denominator or gives rise to the occasion to report the codes for the reporting numerator is billing one of those codes for a patient.

So if for example, we're talking about (E&M) service codes, every time a patient bill is sent in with one of those codes, it means that one has to report the numerator code to report for that applicable case. And one has to do that in 50% of applicable cases.

Now, that means that in large numbers of the patients for office visits that it would be necessary to report this code, without regard to whether or not a prescription is actually written at that visit.

That sounds somewhat burdensome possibly in that is the requirement that was set in statute 50% of applicable cases. Hopefully, the ability to make this a routine consideration in submitting bills and to submit these numerator codes along with the regular billing codes and the ability to adopt that routine will make it less burdensome since that will be something that will be incorporated in the routines of practice.

We don't really have the discretion to reduce that number being the low 50%, so it's not something that we specifically had any ability to modify. What we can do is help people understand things but we don't have the ability to change that 50% requirement.

Again there are some specifications that might change between now and December 31.

So when one has the occasion to report the numerator code or the reporting code, there's three basic things that one can report. And I'll get to those in a second.

But insofar as one reports any of those three codes, they're saying something else. And that is that as I mentioned before that they have a qualified electronic prescribing system.

Yup, there is no - so each time those numerator codes are reported, even if the numerator code is - I didn't write any prescriptions, they're also saying, however, I do have qualified electronic prescribing system adopted in the bill.

And there are several requirements for that and I'll refer you to some of the information we have on our Web site. But basically, the four qualifying elements for electronic prescribing system are generating a complete active medication list, incorporating electronic data received from applicable pharmacies and PBMs if available.

System must allow eligible professionals to select medications, print prescriptions and electronically transmit the prescriptions and conduct alerts.

Must provide information related to lower cost therapeutically appropriate alternatives if any, which can be filled by having access to - having the capability to receiving tiered formulary information.

And the fourth requirement is that ability to receive formulary, tiered formulary information.

So the details of this are on our Web site. And I would refer you to that. There in the measure itself, which the 2009 measure has been tentatively finalized and we will - and it has currently been posted as of the last day or so.

So we'll give you the link to that and where you can go forth, but the details of what constitutes a qualified electronic prescribing system are available in the measure, the measure tells you exactly what reporting denominator is and what's the reporting numerator is and I will refer you to that that when I give you some information on these links.

We've heard the discussion about Part D standards and I want to make sure you understand how those fit in to the measure.

The MIPPA legislation requires that to the extent feasible and practical, the secretary will require the compliance of Part D standards for this incentive program.

And the way that works is insofar as the Part D standards are relevant to any of the specific requirements for a qualified electronic prescribing system, those Part D standards have to be used for that.

There are other Part D standards such as those standard Rx fill, which will help one whether or not a prescription has been filled. There's an electronic transmission standard that's described in the Part D standards for that.

But that is not a requirement for a qualified system under our program. You'll see that in the measure.

Therefore all that is the Part D standard and there's again a requirement to comply with Part D standards for the incentive program, since it's not one of the basic qualifications required for the system, then that Part D standard is irrelevant for the Part - for the system - for the aspect of the Part D standards.

The standards as has been previously discussed refer to the version of the messaging that the E-Prescribing program uses to send the information over the prescription (unintelligible).

I talked about a reporting denominator. There are a number of codes and one basically would need to look carefully at the codes because any time one of those codes and again there are several, any time any one of those codes would be submitted on a bill for claim, those HCPCS codes.

And then it would give the occasion or that would an applicable case in which the measure is reportable. And if a professional never wants to submit a bill with one of those codes, then that professional can't qualify as a successful electronic prescriber because there's never been a denominator code.

But as long as a report at least once, then there's an occasion to report the numerator.

In general for PQRI, that would be sufficient to qualify if a person had only one patient that dealt with three measures, they could report that one patient and would be 80% of the time and that person theoretically that's an unlikely to happen, but theoretically would qualify for the PQRI incentive and get the - for 2009 2% of all applicable - all Part D allowed charges.

That doesn't work that way in the electronic prescriber program. There's an additional limitation that the statute plays, which is that in order to get the incentive payment, the professional's denominator code charges, that is the total charges for bills that involved one or more of the denominator codes in this measure has to make up at least 10% of the professional's overall Part D allowed charges and try to bring that down to something more understandable.

There are no, for example, hospital emergency department professional codes in the do not reporting denominator. But there were office visit codes.

So if I'm a physician that most of the time works in the - exclusively works in a hospital emergency department, then I would not be able to report any measure.

If I report it - if I work in the hospital emergency department most of the time, but 10% of my charges came from codes from the office visits, then I would have at least 10% of my total Part D allowed charges that fell into this reporting denominator and I could report the measure.

Similarity a cardiac surgeon, cardiac surgery codes are not in the denominator. But if the cardiac surgeon had an office practice and reported these - and build these office visit codes, and if the charges for them amounted to 10% of the overall allowed charges, then that practitioner would be eligible for the measure.

So it works that way for the incentive and that limitation also applies to the penalty.

So it's sort of a balance here that if they're eligible for the incentive, based upon that 10% of all - of denominator code Part B charges, then they would be liable for the penalty.

But if they're not eligible for the incentive, they wouldn't be liable for the penalty.

Now that's of course, based upon the assumption, the operating assumption that the way this would work in the future would be based upon this reporting measure.

But the secretary has the option or the alternative to change the criteria for determining whether a person is a successful electronic prescriber. And specifically - well if you look - if you think about the system we have right now, where one reports a measure one might say, gee, this is about electronic prescribing.

It seemed sort of out of step with some electronic concepts or transmission of the efficiency of that. So it requires that we electronically prescribe and then tell you about it on a claim form. And we would agree with that.

However, this - the statute was passed in July and it is required to be implemented in January and we do not have the feasibility or capability to do anything other than handle the successful electronic prescribing (unintelligible) through the use of this measure.

But we have the authority in the future to make the determination on whether a person is successful electronic prescriber based upon a certain number of Part B prescribing events (unintelligible) the

limitation that is unlike 10% of charges for this denominator codes, it would be the prescriber prescribe a certain number of Part D prescriptions may be 10, 50, 100, 1000, no specific number but we would pick a number and then using Part D data that would come through the Part D claim system, not from the doctors but from the pharmacy benefit plans, we would be able to determine by the use of Part D data when that is implemented that the prescriber electronically prescribed.

So in short, what it mean is we would have the - we have the authority to use a system whereby the doctor just has to electronically prescribe and we would figure out whether they prescribe enough and whether they electronically prescribe enough and if so we would forward an incentive (theme) to them.

That is a lot easier in terms of burden. It requires really nothing for the doctors to do is just that we cannot implement that currently and there are certain practical steps we have to be taken to be able to do that.

We're hoping we'll be able to do that in the relatively near future possibly as early as for the 2010 (unintelligible). It can't be done for 2009 and we've described that in the physician fee schedule rule.

And so for now, so what - the way - the reason I bring that up at this point is that possibly for the future, the way the penalty will work is it'll be based upon these other parameters, number of Part D prescribing events, number of electronic prescribing and won't really be based upon these current denominator codes.

If that were to be the case, it would be, I think, one of the factors that would be taken into account whether or not a prescriber was eligible

for an incentive program in 2009, there is a hardship exemption as well that the secretary can apply.

So there are a lot of considerations that will have to be taken into account in the future in terms of how the penalty will apply. No decisions have been made with respect to that. But I think we're quite cognizant of the fairness element here in terms of how that would apply in the future.

And that will be the subject of rulemaking and the secretary will make some proposals and based upon those proposals, comments would be considered and ultimate - final approach to that would be stated.

So we've talked about that most of these things. I want to just finish up before I turn it over to Dr. (Green) in terms of selection of a system.

As I mentioned, the number 1 thing that one has to do is have a system to be able to qualify for the incentive.

And to select the system, one would have to take into account the functionalities that I mentioned that are included in the measure, has to take into account that those functionalities comply with Part D standards.

And so, how does one know that?

Well in - we - it would be necessary to deal with vendors and talk to them about it and take into account those things and get those questions answered. There's a couple of shorthand considerations. And that is that electronic prescribing sometimes is part of a electronic health record system and sometimes it's a stand-alone system.

(If it's an) EHR component, then there is a CCHIT certification that applies to EHR systems and insofar as the EHR system needs 2008 CCHIT certification standards then that system does have, you know, and does - it does have the functionalities that are mentioned in the measure.

And so again, 2008 CCHIT certified EHR systems with the E-Prescribing module, that would comply.

CCHIT does expect to review stand-alone systems for certification in 2009 and what that means, although they cannot - the vendors could not state that they have any kind of such certification for stand-alone systems, they could give some assessment of their commitment to comply with such standards in the future that might be informative to a potential customers of those vendors.

As part of Part D standards, again, that's something that one would ask the vendor, but a shorthand way of making some assessment of this is that, there is a SureScripts-RxHub, process for the electronic highway and that there is a list on their Web site of the vendors that use the system and thereby comply with the Part D standards. So that would be a shorthand way of making such a determination and it's - electronic prescribing system is not on SureScripts network, then one would need to discuss the specific Part D standards, which we go through in detail again on physician fee schedule rule and discuss that with the vendor.

We - I'm going to turn this, ask somebody else to give the reference to the Web site and where we have these things posted, but - oh okay, I've been shown where the URLs are.

But I think we'll have to post this and this will be hard to state, but we have on the PQRI Web site cms.hhs.gov/pqri, we have information about the E-Prescribing incentive program there.

And on there, there's a Measures Page) and on there, they'll be able to find the electronic prescribing measure. And I also mentioned the Medicare physician fee schedule, but these different links and downloads will be available to you on the PQRI Web site.

We have also recently completed a conference in Boston that was put on by the secretary with the (others) collaborating on that and there's information on a Web site that's - for that conference, so that people will find helpful.

So with that, that's the overall incentive program, some aspects of the measure. At this point, I want to turn it over to Dr. (Green) who will reiterate and provide a little bit more detail about the measure and how it works so that, hopefully, you'll understand it well.

I think before I turn it over to him, I do want to mention that in this particular measure, one distinct advantage is unlike PQRI measures where some of them have age limitations or gender limitations or specific diagnosis, the denominator codes in this are purely HCPCS billing codes, and so it makes it somewhat simpler in that respect.

So with that, I'll turn it over to Dr. (Green).

(Green): Thanks, (Mike).

I'd like to welcome everyone also and thank you for your attendance for today's Electronic Prescribing call. We're excited to have you here and appreciate your interest in our electronic prescribing program.

Just to reiterate what Dr. (Rapp) said, there are two key factors to report and participate in the electronic prescribing incentive program.

First thing is as Dr. (Rapp) had mentioned, you must have a (user) qualified system. And as Dr. (Rapp) also mentioned, there are four components of a qualified system.

One is that it has to generate an active medication list incorporating electronic data which is received from (applicable) pharmacies and Pharmacy Benefit Managers or PBMs.

Now, the system has to have that functionality. We recognize that that information may not be readily available from every single PBM, but your system has to be able to receive it if it is available.

Similarly, the system has to be able to select medications, print prescription, electronically transmit prescriptions and conduct all alerts. And we just describe the alerts basically as written or acoustic signals that one prescriber a possible undesirable or (unfaced) situations including potentially inappropriate dose or (unintelligible) administration of a drug, drug-drug interactions, allergy concerns or warnings and cautions.

The third component is to provide information related to lower cost therapeutically appropriate alternatives, if any, exist. And the availability of an E-Prescribing system to receive tiered formulary information, if available, would be this requirement for 2009.

The fourth requirement, again, is to provide information on formulary or tiered formulary medications, patient eligibility and authorization requirements that are received electronically from the patient's drug plan, again, if this is available.

So the system has to be able to receive it and we recognize that it may not be available in every single instance. And so the industry catches up, but the system has to be able to receive it. And again, it has to be done all using the Part B standards that (Drew) and Dr. (Rapp) mentioned earlier on the call.

The second important part and this, I think, is where folks have gotten confused, at least I received a lot of questions in going around doing some of the talks and presentations about E-Prescribing.

Ten percent of a person's - of the provider's Medicare Part B charges must be comprised of the codes that make up the denominator of the measure. And as Dr. (Rapp) described, there are several ambulatory codes that do make up this denominator.

This includes psychotherapy codes (908-01) through (908-09). There are some ophthalmology codes for eye visits, for new patients and followup. There are also some health and behavioral assessment codes. There are also the new patient (E&M) codes (99-201) through (205) and the followups (99-211) through (215).

There are additionally - or the (99-241) through (245), which are the consultation codes. There currently is a pelvic exam (G0101) code as well as the two diabetic teaching codes, which are (G0108).

Now, as Dr. (Rapp) explained, the secretary has the authority to make some modifications in these through the end of this current year.

So to give a concrete example, if there's a gastroenterologist, for instance, that wants to be able to report this measure and has $100,000 worth of Medicare covered Part B charges for year 2009, if, let's say $15,000 of his or her charges are made up of these codes that appear in the denominator and the 80 - other $85,000 of his or her charges are comprised of colonoscopies and other endoscopies, this eligible professional would be able to report this measure because, again, more than 10% would - of his or her charges would be comprised of the codes that make up the denominator.

If on the other hand $95,000 of the $100,000 worth of charges were procedure related, meaning colonoscopy, endoscopy or something else, then that eligible professional would not be eligible to report this measure in 2009.

So that's an important thing for folks to look at when deciding whether they want to participate.

Assuming they are eligible to participate as we just described and they have the qualified system as outlined in the measure, there are three G codes associated with this measure.

The first G code, (G8443) basically says that all prescriptions that were generated during this encounter were generated using a qualified electronic prescribing system.

Second code (G8446) basically says that the provider does have access to a qualified electronic prescribing system, but some or all the

prescriptions generated during the encounter were printed or phoned in because of state law regulation or federal law regulation, patient request or the pharmacy system was unable to receive the electronic transmission or because the provider was writing a prescription for a narcotic or other controlled substance.

The third G code basically, which is (G8445), says that no prescriptions were generated during this encounter, but again, the provider does have access to a qualified electronic prescribing system.

So that, basically, you know, folks talk about the burden of reporting this measure, these three G-codes could be added to a super bill and basically next to each G code you can say, you know, all prescriptions (yes), no prescriptions created or phoned in for accessible reasons. So we recognize that there is a bit of a burden with this. But again, through repeated use, we don't feel that it will be overly excessive.

Just a couple other quick points that I wanted to make, just to be clear, this program is separate from the 2009 PQRI program. If an eligible professional does report successfully on three measures in the PQRI program in 2009, they would be entitled to receive a 2% bonus of all their - excuse me - 2% bonus of all their Medicare Part B charges.

On the other hand - and in addition, I should add that if someone electronically prescribed and they're successful at that they would be entitled to receive an additional 2% bonus for the - on all their covered charges.

Folks that are not eligible to receive this incentive because they don't meet the 10% threshold that I just described, so of course, can freely

voluntarily report this measure. Unfortunately though, they would not be entitled to receive the 2% payment that we described.

The last thing is we want to encourage folks to adopt electronic prescribing. You know, there's always - folks are always resistant to adopt any new technology due to the cost and the disruption (that appear) in their workflow in their office.

But in having spoken with several physicians who are actively using electronic prescribing in their office, they've all described how it really has improved the quality of care their patients received and it also made their office run more smoothly. They don't get calls from the pharmacy as often or they're holding for a pharmacist, so the pharmacist is holding for them for refills or renewals and it really has made things flow more smoothly.

And the last thing I would suggest is as Dr. (Rapp) described the details of the bonus incentive payment as well as the potential for future penalty, clearly it makes the most sense to try to adopt this and participate in this program as early as possible because there are two full years where you can receive the 2% bonus and then transitioning to a 1% bonus in the future.

And the earlier you jump on, the better chance you have will not - you will have only to pay for your system, but to actually make a bit of an additional incentive payment through reporting this.

So with that, I will try to wrap up so we can leave some time for some questions. I'm going to turn it, I guess, to (Natalie) and Paul Cotton is on the phone.

Man: (Dan), let me just make a - I just want to make sure that one point is clear about the 10%.

The 10% is a limitation that would be applied when a calculation for payment would be made. So it's going to be little hard for somebody to predict absolutely whether their denominator charges make up 10% of the overall charges.

So I think it's useful probably for doctors - who are trying to make a determination whether to participate in the program to make some judgment about that, but first of all, one really doesn't know each other (unintelligible) and it's a determination or a calculation the CMS will make prior to issuing a bonus.

The issue for the physicians is do I want to participate if they see that it's obvious that only 1% of their charges and they wouldn't expect any more than that to be within the denominator, well then it's unlikely they'd be able to qualify. But there's nothing that stops one from reporting and this will just to be applied at the end as the determination where there are payments made.

The other thing I want to mention about is narcotics. That there has been some proposals made to make it possible for doctors to electronically prescribe narcotics.

And however, there have been some comments made that these - the different proposals that have been made would be still impractical or unworkable for doctors in many respects.

And so, just to make it clear that the way this measure works, that it's unacceptable in terms of reporting to indicate that I did not e-prescribe because it was a narcotic. That's one of the G codes specifically.

One thing you can't report is I didn't e-prescribe because I didn't feel like it. You have to - the only three things that can be reported are, I e-prescribed everything, I didn't do any prescriptions or I did prescriptions, but not all of them were e-prescribed for one of several acceptable reasons such as patient request, state law narcotics or the pharmacy code received at that time.

But there is no G codes that says I didn't e-prescribe because I didn't feel like it today. That would fall into the 50% (flax) that one is given and so far as one only had to report 50% at the time.

So back to you, (Natalie).

(Natalie Highsmith): Okay. Thank you, Dr. (Rapp) and Dr. (Green) and (Drew Morgan). And (Laurie), has Paul Cotton joined us?

Operator: Yes, he has.

Paul Cotton: I'm here.

(Natalie Highsmith): Okay.

And Paul Cotton from AARP will talk about a consumer support and they have done some research and today, Mr. Cotton is going to talk about his findings.

Paul Cotton: Thank you very much.

I want to thank everybody else who have been speaking so far. They've been so very thorough that I'm going to be able to cut about two-thirds of my remarks down and just get to the nitty-gritty here.

When we did the E-Prescribing conference up in Boston, it became very clear that there is a widespread misperception among many physicians that older patients in particular will be resistant to E-Prescribing.

We had done some research that (on the office) that is too overwhelmingly older patients very much want physicians to use E-Prescribing. They, by and large, don't know what E-Prescribing is and you have to explain it to them. But once you explained what it is, how it works and what the benefits are, the (resistant) overwhelming response in favor of doing it.

The survey we did was called Healthy @ Home, and it looked at a whole range of electronic services and technologies that can help people age at home so they don't have to go into nursing home.

And in the survey, they referred to E-Prescribing as telepharmacy. The results are really quite outstanding. Over 95% that they want their physician to use E-Prescribing to check their medication history, 73% strongly wanted their physician to do that, 95% also wanted their physician to use E-Prescribing to check their insurance coverage to make sure the drug is covered by their health plan before they leave the doctor's office, and 67% strongly wanted their physicians to do that.

Then 92% agreed that they want their physician to use E-Prescribing to send the prescription directly to the pharmacy so that when they get there, it's ready for them to pick up and they don't have to wait around, 67% strongly agreed with that.

So you can see from those figures, there is very little resistance to E-Prescribing among older Americans and as soon as you explained this to patients, they very much want them to - their physicians to use it.

So we want - we are very strong supporters of E-Prescribing. Our members are very strong supporters of E-Prescribing. We work with the e-Health Initiative to produce the consumers guide to E-Prescribing. It very clearly explains the benefit of E-Prescribing in language that consumers can understand.

It should help ensure widespread acception - acceptance of E-Prescribing when physicians adopt this. It's on the Web at ehealthinitiative.org. I'd encourage you to look that up and if you'd like the Healthy @ Home survey, that's on our AARP Web site.

If you go to our Web site, just go to the search function and enter Healthy @ Home, Healthy with the @ sign you use in an email address, Home, and that should bring up the survey.

Thanks.

(Natalie Highsmith): Now, we will move into our open Q&A portion of the call.

(Laurie), if you can just remind everyone on how to get into the queue to ask their question and everyone, please remember (when it is your

turn), to restate your name, what state you are calling from and what provider or organization you're representing today.

And (Mike), let the folks know that we do have close to not over 1000 people on the phone line, so we would like to move through questions as quickly as possible so we can have enough people asking their questions today.

(Laurie)?

Operator: Thank you.

I would like to remind all participants if you have questions, you may signal us at this time by pressing star-1 on your telephone keypad.

Again, that's star-1.

If your questions is asked and answered and you would like to remove yourself from the roster, you may do so by pressing the pound key.

We'll take our first question from (Robyn Desami) in Arizona.

(Robyn Desami): Hi. Well I have a question about - more about the stand-alone E-Prescribe systems, of what allows it - to be qualified system with CMS in particular, as I go back on my notes, is there something about - do they have to supply a certification through the CCHIT?

Man: No. There's - basically, I was - the qualifications for the measure are the same regardless of whether it's an EHR based system or stand-alone system. It's just that we were talking about CCHIT certification

as a shorthand way of knowing whether the system one is purchasing meets the qualifications in their measure.

But the qualifications don't change whether it's an EHR system or stand-alone system. There is no certification system for stand-alone systems currently. That's why there's no shorthand way of determining that the system meets the qualifications using the CCHIT certification.

There is for EHRs in that if it meets the 2008 CCHIT certification standards, if the vendor says this EHR meet - is CCHIT certified using 2008 standards, then you know that it meets the qualifications for the measure. Otherwise, one will have to determine it, but one would do that by talking to the vendors. So there's - that's what that was for.

(Robyn Desami): Okay. And my second part to that is we're not going to find out until the end of the year if our system is actually going to be qualified through CMS?

Man: No, no. That's (somehow) we don't qualify systems. This is a - basically, a paper reporting measure. So the professional is stating or in submitting the G codes that I have a qualified system.

(Robyn Desami): Okay, got it. Thank you very much.

Operator: Our next question today comes from (Careen Ruben) in Washington, DC.

(Careen Ruben): Hi, (Careen Ruben), the American Academy of Ophthalmology.

I noticed today in the latest stuff that you posted that it says now that the payment will be made on the estimated allowed charges. Why does it say estimated since CMS will know the charges per physician and how are you going to estimate it?

(Mike Rapp): That's the same as the PQRI and it's a statutory. And it's based upon the idea that - first of all, there's a time that the statute says that the charges that the claims in, which is at the end of February of 2009.

And at that point, there is a certain processing time, so there's an estimate factor that's put in there to make sure that even though it hasn't completed the processing, it basically adds to what has been - that one knows about and there's a fudge factor to add to it.

So it has to do with the claims processing, but it's essentially the same. It's not an effort to do something different. It uses the information we have and adds a factor to it.

Man: And, (Careen), you can imagine, providers have more than two months to submit claims under Medicare.

Unfortunately, due to the time, it takes up to process the PQRI data and essentially the electronic prescribing data in the future, we have to cut off receipts of these claims as of February 28 of the next year as Dr. (Rapp) said. So for 2008, it will be February 28, 2009, and for 2010, it will be February 28, 2010.

So that's where the estimate comes in because technically, a provider could submit a 2009 charge in April or May of 2010. But again, we have to set some final limit how to be able to process it and get the payments out to the subscribers.

(Mike Rapp): In other words, it advantages the professional rather than disadvantages the professionals.

(Careen Ruben): Okay.

Operator: Our next question comes from (Sarah Reed) in Missouri.

(Sarah Reed): Yes. I have two questions actually. The first one deals with incident two billing.

If a nurse practitioner is providing the services in the office and prescribing, but the physician is being built under the position, is this going to have any effect on this because that’s how we, you know, bill incident to services?

(Mike Rapp): Well basically, the way the determination for eligibility for an incentive works is on the individual professional basis based upon the (MTI). So it will come down to who's (MTI) is being used.

(Sarah Reed): For billing, it would be the physician.

((Crosstalk))

(Sarah Reed): But for prescribing, well...

(Mike Rapp): It would be then the - it would be the individual physician that would apply to it. The individual physician would have to report the G codes and would have to, you know, would be the (MTI) there, but then - (Pat), do you have any?

(Pat): No. I think it's basically the - I think our incentive (model) - incident, (too), I mean (unintelligible) is if the nurse practitioner is doing a service and a physician feels as if he or she actually did the service.

Man: Yeah.

(Pat): So the physician (unintelligible) would be on the claim.

(Mike Rapp): Right. So...

(Pat): And for question is (enough circumstance), it's the nurse practitioner that e-prescribing. But the physician we are recognizing incident two with the physician...

(Mike Rapp): Right.

(Pat): ...with the physician qualified.

(Mike Rapp): So we treat it as - from billing purposes, it's treated as if the physician is doing the prescribing even though technically the nurse is.

And so it would work in terms of - we would look for the denominator for that and any other services using those codes that the physician build, both incident two and the non-incident two. And then the incentive would be based upon 2% of that physician's total log charges including the ones that were incident two.

Woman: Now, I think I understand this other question, but I just kind of want to walk through it to be sure.

We have a couple of surgery groups and a cardiac practice and a lot of times, the patient is seen in the hospital ahead of time or is seen in consultation and medication is not prescribed.

And we would - if it were hospital, we would not be able to submit that. But if it were the office, we would be able to submit presurgery or consult with the codes that says that no medication was submitted.

But post-operatively, the patient is put on pain meds or the cardiac medication has changed and the code (99024), which is the no charge post-op code which everyone will be using for post-op is not - doesn't really - it's just in the system so you know you saw the patient. It doesn't really get submitted to you all, but that's where the code showing that we were e-prescribing would be attached.

And so, in that case, those physicians would only be able to submit the charge from their office ahead of time saying that they didn't prescribe but that would count.

Man: Okay. So then one code that you mentioned, the 99...

Man: 024.

Man: ...the (99024) is not one of the denominator codes?

Woman: It's not.

Man: So that - but it wouldn't mean nothing to say about that.

Woman: Right.

Man: The only time that one submits the numerator codes is where the denominator code is on the claim.

Woman: And only...

Man: There's no absolute requirement for a certain number of codes. It just comes down to - those codes have to represent 10% of all the Part B charges for that particular individual professional.

Woman: Well and...

Man: Even if that professional is not actually prescribing as - in the case you illustrated at the pre-op visit and they report the codes that no medications were prescribed, that counts for a reporting.

Woman: Okay.

Man: The post-op visit, which is part of the bundled service...

Woman: Right.

Man: ...whose code does not appear in our denominator whether they prescribed or don’t prescribed, there's no G code to be sent in with that. It doesn’t qualify to be reported upon.

Woman: Okay. I just wanted to be sure we understood it clearly. Thank you.

Man: Thank you.

Operator: Our next question is from (Joy Wilson) in Maryland.

(Joy Wilson): Hi. This is (Joy Wilson). I have a question about the actual (unintelligible) specification. There's the first bullet where it says under (prescription), generate a complete active medication list incorporating like trying to get a receipt from (unintelligible) (little) pharmacies and benefit managers if available. What's this if available means? If it's not available, it's okay?

Man: Well obviously, we would prefer that information were available because then you'll know what other providers have prescribed for that particular patient have increased this patient safety and quality of care.

However, we recognized at the same time that the - not all the PBMs may be up to speed in having that information available to an individual eligible professional.

Despite that however, the eligible professional system must have the capability to collect that information if it can be provided by the pharmacy benefit managers. So even if the pharmacy benefit manager A cannot provide that information if - to that particular patient, the next patient that comes in may use pharmacy benefit manager B. And if that information is available using that pharmacy benefit manager for the next patient, then that information should be able to be retrieved by the qualified system.

(Joy Wilson): So your system has actually to have that capability of doing it regardless of whether it'd be pharmacy itself can.

Man: That's exactly right.

(Joy Wilson): And the other question I have is about registry. Is e-prescribing not allowed to go through just re-billing?

Man: That’s by registry submission, you mean that’s...

((Crosstalk))

(Joy Wilson): Submissions like - I'm sorry, like submissions like (PQRI) has now registry that are approved. For e-prescribing, you cannot go through any registry, is that correct?

((Crosstalk))

Man: It can for 2008 but not for 2009 where...

((Crosstalk))

(Joy Wilson): Not for 2009.

Man: Exactly.

Man: You can do it for PQRI). You can't do it for the electronic prescribers incentive program.

(Joy Wilson): And I'm sorry, I have one more question.

Where it states on the fact sheet in October, it's determined appropriate by secretary the eligible professionals does not submit a significant number. Is that like under 10% of your claims? Is that what you mean it's not significant?

Man: That it refers to what I was talking about that one (particularly) the secretary has the authority to switch from 10% of charges represented

in these denominator codes; two, a certain number of Part D prescribing event. We're not doing that for 2009. That's in the future.

(Joy Wilson): Okay.

Man: And the secretary would pick that number based upon notice and comment rulemaking.

(Joy Wilson): Okay.

Man: So we can switch to the limitation not being 10% of the charges in a certain set of denominator codes, but being a certain number of Part D prescribing event. So it would be like the prescriber - if they prescribe at least 500 Part D prescriptions, then they would be eligible for the incentive program and liable for the disincentive, or it could be 100 or 1000. That number would have to be determined.

(Joy Wilson): But that has not been determined yet and that won't be determined for 2009?

((Crosstalk))

Man: Well no. It doesn't apply to 2009.

(Joy Wilson): It doesn't apply to 2009. Okay.

Man: It may apply in the future. That will be subject to future rulemaking.

What that means in rulemaking is we will - the secretary will propose a number and a rationale for it and then the public will have a chance to comment on that and tell the secretary, well, agree with that or we

don’t - and we think that’s too high or we think that’s too low or we think that’s just right. And then based upon that, the secretary will make a final judgment and publish that.

(Joy Wilson): Okay. All right. Well thank you.

Man: You're welcome.

Operator: Our next question will go to (Laura Lovistaylor) in New York.

(Laura Lovistaylor) You didn’t have to try the last name.

Anyway, I'm calling from (Linden) (unintelligible) Physicians in New York. And my question is on the encounter, you have a couple of prescriptions that did qualify and could go and then you have one that was a narcotic and couldn’t go. What code would you use then?

Man: We’d use the (GA446), which basically says (unintelligible) for all the prescriptions generated during the encounter where (unintelligible) that are phoned in due to one of the appropriate reasons, again, the pharmacy...

((Crosstalk))

(Laura Lovistaylor) Okay. So this is say half of that one. Okay.

Man: Yeah. Even though you electronically prescribed, let's say five out of the six medications, she still would report that one G code.

(Laura Lovistaylor) Okay. And can you also clarify to me how we would be eligible for a penalty if we do the program?

Man: There's - what are you - well...

((Crosstalk))

Man: The penalty and how that would work specifically has not been determined. It will not come into effect prior to 2012, the penalty...

(Laura Lovistaylor) Okay.

Man: ...and it won't relate to any reporting that was done in 2009. It would be relayed to our reporting period in 2010 or 2011. So all I can suggest is we will - that will be a subject for discussion next year when the rulemaking process takes place.

For now, I think, although, the penalty I know creates a lot of anxiety, right now, the focus probably should be on the incentive since there's no penalty for whatever you do in 2009, only an incentive.

(Laura Lovistaylor) Okay. Thanks.

Operator: Our next question comes from (Sandy Swallow) in Iowa.

Ms. (Swallow), your line is open.

((Crosstalk))

(Sandy Swallow): This is (Sandy Swallow) from Iowa. And I just wanted to clarify if the fax - if a generated fax to the - from the - if it's generated from the computer going through a fax to the pharmacy, is that considered e-prescribing? Is that exemption been reinstated?

Man: There is a - I'll let (Drew) talk about how the exemption works. But for this incentive program, a computer-generated fax that's initiated at the doctor's office does not count for e-prescribing.

There is a circumstance where e-prescribing takes place and electronically generate a prescription from the office it takes place and it's converted to a fax unbeknownst to the prescriber at the pharmacy end because of the limitations of the pharmacy, that would count as e-prescribing.

Jenna Rowe: Okay.

Man: But if the practitioner intends to only generate a fax regardless of what system is used to generate the fax, that does not count as e-prescribing for the incentive program.

This is - there's - as far as how - there is any exemption or exception, (Drew) can explain how that works. But just - whatever he says, just be clear, it won't count for the incentive.

Man: Right.

(Unintelligible) referring to 2008 (unintelligible) schedule, we proposed to eliminate the computer-generated (unintelligible) subject for those who are using prescription. I'm talking about prescription writers doing (unintelligible) that didn't have the script standards.

After we published that rule in 2008, we got some comments back in the industry (unintelligible) referred to them because (unintelligible) have them refer back to (unintelligible) because they didn't know if

the physicians were able to collect this (unintelligible) request electronically.

So in 2009, we proposed to add that exemption for (refill) request. But as we heard from industry and from physicians and everybody else that, you know, we should leave it in place because with the MIPPA incentive it would create a better incentive for adoption, instead of, you know, the feeling that exemptions (unintelligible) we have done is (unintelligible) computer-generated fax exemption in place for 2009, but we will be lifting it in (unintelligible) as well (unintelligible) under the incentive (unintelligible). We will give physicians who are currently using the prescription writers that do fax only (unintelligible) to adopt the (unintelligible).

Man: But I would point out that the - if the rationale here is based upon refills and the way the incentive program works, there would be no charges would seen generated from refill request that come from a pharmacy. These are office visits specifically. So the refill in those issues don't really have anything to do with this. So...

Man: Right.

Man: That answer your question?

(Sandy Swallow): I think so. Thank you.

Operator: Well the next to (Jamie Steph Painter)...

Woman: (Unintelligible).

Operator: ...in Wisconsin.

(Jamie Steph Painter): Hi. This is (Jamie Steph Painter) from Wisconsin, (Dean Health System). So I just have a few questions, and I'll try to go quick knowing your timeline.

When you talked about qualified system and the word “can” and I hate to reiterate or ask for more time, but if we have a system on a (world) system that the company can do all of those pieces but you're not on the software version that handles all of those pieces, does that make you not qualified system when you look at how many different versions in getting to the (unintelligible) upgrade?

Man: Well I think you need to look at the specific elements (to be able) to generate a medication list, et cetera, needs to be able to do the alerts, needs to access formularies.

So I'm not quite sure what you're referring to, but the system needs - the qualified system has to be capable of doing these things whether they're actually used may not - there may be some limitations there based upon the parties that one is interacting with, but the system itself has to be able to do these elements.

(Jamie Steph Painter): Okay.

My second question is for mail order knowing what the SureScripts are (unintelligible). They haven't told you how you can do the mail order component, so how would you currently hold that as a numerator code if you're not able to do that?

Man: I'm not sure how the mail order has to do with the office visits?

(Jamie Steph Painter): Because you're still visiting - you're still seeing patients under those codes, but their prescriptions need to be sent to mail order companies or mail order PBMs, which at this point you can't always electronically send to.

Man: If they're not available for electronic prescription you'd report that you have a qualified system and you would otherwise use it or choose it for the (GA446). The pharmacy - if it's unable to give you the data so that the prescription was prevented or founded for that reason.

(Jamie Steph Painter): Okay.

And then my final question is what happens if you use one of those decodes in the enumerator and you put it in good faith when you're sending it? For example, you're sending the office visit (bill) and everything was electronically prescribed, but something happened where it gets rejected or the system is down at the other end of the pharmacy. It's already been sent by the provider and then you get it up.

Man: And it sounds like in that case when you submit the codes you are in good faith indicating that they were electronically prescribed and you're not aware of any problem at the end and I - you wouldn't need to resubmit anything. You would just leave it the way it was.

Man: I mean, if you know at the time, you know, that the message is rejected from the pharmacy because the system (unintelligible) again, there's that (GA446) that the pharmacy system (unintelligible), but as Dr. (Rapp) said, if you don't find out about it, you fill out the bill, you've spent the (unintelligible) of the measure, which is to electronically prescribe. I mean, you can't be held accountable for something you don't find out after an hour or a day later.

(Jamie Steph Painter): Thank you very much.

Man: Thank you.

Operator: We'll take our next question from (Zelda Price) in Michigan.

(Zelda Price): Hello. This is (Zelda Price) from Grand Rapids, Michigan, Multi-Specialty Grand Rapids Medical Specialist.

My question is so many of our physicians see - probably 52% of our patients are Medicare. Now, this applies only to the straight Medicare, not to the Advantage Medicare product as I understand.

My second part of this question would be, you do not then get credit for any scripts that you fill in E-Prescribe where there is not an office visit where a patient is just calling in for a refill.

And if that is so, do you see that changing down the road to get credit for those that you just refill and you e-prescribe what's on the office visit?

Man: Well I'm not sure what the implications are getting credit for.

Once you qualify for the measure by in - for applicable office visit, you report this information. Once one qualified the incentive payment applies to all of the estimated Part B -- as in boy -- allowed charges.

So one gets credit in the sense that the incentive payments applies to all of the services that are rendered by the professionals for these particular codes and for any other codes for that matter.

So there's not need to - you're not getting cold credit or an incentive payment based upon how many times you electronically prescribed. There's basically an all or nothing you are a successful electronic prescriber when for this denominator codes, you report 50% of the time.

And if you do that and you've got 10% of your total allowed charges for those codes that comes to - 10% of your total charges, then you're eligible for - then the incentive will be awarded, and it will be based upon 2% of all of your allowed charges.

(Zelda Price): Okay.

Man: Similarly a provider would not be penalized if the patient calls over the weekend and they're not in their office, so they may have not access to their electronic prescribing system and they phone in a prescription for that patient. That wouldn't count against them either.

(Zelda Price): Okay.

Man: To answer your first question about Medicare Advantage, this is a Medicare Part B program, B as in boy. It does not include Medicare Advantage.

(Zelda Price): Okay, all right.

Can I ask another question?

Man: Yes.

(Zelda Price): In 2010, did I hear you correctly in saying that perhaps it will be available and recognized through SureScripts or through the pharmacies when we e-prescribe rather than using the G code when we post?

Man: I didn’t say that exactly. But the way the Medicare Part D works is there are claims that come in from the pharmacy - from the benefit plan.

Man: Yeah.

Man: And so, we are looking toward the possibility of being able to have those claims that come from the pharmacy - from the plan tell us whether or not an individual doctor electronically prescribed and we can already tell the degree to which they’ve prescribed.

So once we have those components in place, then the doctors won't have to report the G code. That’s correct. They would just simply e-prescribe, and we would know whether they're e-prescribing to the level that is required to get the incentive payment - we just make the payment. But all that would be subject to future rulemaking, describe, propose, and get comments and feedback and we’ll indicate - and then finalize it based upon that.

(Zelda Price): That would be awesome because right now there are many insurance companies out there that already attract things based upon generic prescribing by the claims that are filed to them from the pharmacies.

Man: Yeah. There is...

((Crosstalk))

Man: Yeah. Right. Thank you.

There is already a lot done. It's just that it's not - we don't have quite the data yet that would permit us to make the determinations that we would need to make authorize the payments that statute provides for. But we agree with you that this would be a tremendous step forward.

(Zelda Price): Thank you.

Operator: We'll take our next question from Gresham Bayne.

Gresham Bayne: Gresham Bayne, Academy of Home Care Physicians in California.

Given the problems of polypharmacy in the homebound elderly and the on national strategy 1.3.9, indicating we should try to remove technical, financial and workflow barriers to the treatment of patients outside of the traditional office setting. I was wondering if someone could explain to me the rationale of not putting the home visit and residential care facility family of codes in the denominator.

Man: Originally, when the measure was developed, it was part of the PQRI program to part 80% reporting and we not want to penalize providers who did not have mobile systems in their effort to be able to submit this measure. But it accounts towards their 80% required denominator.

As such, you can see that they're not emergency room codes, they're not hospital discharge (as opposed) in this measure either again because providers could unexpectedly be thrown into the denominator that might diminished their ability to report.

And similarly again, you could have a provider who is a medical director of a nursing home who sees quite a few of their patients or at least quite a few of their charges in the nursing home and the rest of their practices may be spent in the office. If they don't have access to their system in the nursing home, that could be a problem for them in terms of meeting measure.

While we would agree with you and we would encourage everybody to electronically prescribe, the intent of this first version is to try to capture the folks that prescribed the most which typically would be your ambulatory physicians.

Gresham Bayne: What would be the process? You said HHS has the ability to change before the end of the year. What's the avenue for petitioning for that change because home care physicians don't have offices. That is a characteristic of the private practice.

Man: How do they e-prescribe?

Gresham Bayne: They e-prescribe with the (Aprocrities) or other handheld instruments or through EMRs that they will carry on tablet computers into the wide area network.

Man: And do they not have - so, one thing I think that needs to be pointed out is even though they couldn't report these codes for the home visits since they're not in the denominator, they could report them for office visits. And they would still get the 2% for the home visit as well, it's just they wouldn't be able to report it for those.

Are you suggesting that there are substantial numbers of doctors that do or could e-prescribe and that only do home visits and don't have any office occasion to do office codes?

Gresham Bayne: That's right. There're about 4 million Medicare paid house calls a year and the overwhelming majority of them are made by physicians who don't have an office practice there. They make only house calls to the home-bound elderly. So we'll never qualify with the 10% of charges made up in the denominator as currently written?

Man: Why don't you give us your telephone number, we can give you - we'll contact and tell you how you could communicate your suggestions.

Gresham Bayne: Thank you.

((Crosstalk))

Gresham Bayne: Should I do that online here?

Man: No.

Gresham Bayne: 858-373-2402.

Man: What's your name, please?

Gresham Bayne: Dr. Gresham Bayne, B-A-Y-N-E, with the American Academy of Home Care Physicians.

Man: Okay. We'll give you a call.

Man: Just one other thing, Dr. Bayne, to point out real quick.

By putting those notes in the denominator would at this point make all providers who do home health visits subject to potential penalty in 2012, again, not based on 2009 participation but on future participation. So if those folks don't have access to a qualified system….

Man: We'll give you a call.

Gresham Bayne: Thank you. I understand.

(Natalie Highsmith): Okay. (Laurie), we have passed our five o'clock hour here in the East Coat. I will now turn the call over to (Drew Morgan) or Dr. (Rapp) or Dr. (Green) or even Paul Cotton if they have any closing remarks?

(Mike Rapp): Well this is Dr. (Rapp). I'll just close and thank - we're quite enthusiastic about this electronic prescriber program.

We've tried to provide a lot of information to people. It's an interesting program since it is, I think, a first what I'd call pay for performance rather than just pay for reporting because it does require one to have and use the electronic prescribing system, provides the important incentive based upon one measure.

We are hopeful that it will have a very important role in stimulating the widespread adoption and use of electronic prescribing. We thank you for participating in the call today. We look forward to providing a more detailed information for you as time goes on. But we are also pleased that we gotten quite well - I think I delineated for people to

participate, and we'll be happy to make any further questions that you'd have in the future.

And in addition, I believe we have another open door forum for electronic prescribing scheduled for December 11. So this will give you an opportunity to fill in some of the gaps that maybe weren't covered in this call. So thank you all for participating.

(Natalie Highsmith): (Laurie), can you tell us how many people joined us on the phone line?

Operator: Today, we have 1,083.

(Natalie Highsmith): A thousand eighty-three, wonderful.

Again, we do have another one scheduled for December 11. That one will be starting at 3:30 again, Eastern Time. Thank you and see you all then.

Operator: Thank you very much, ladies and gentlemen, for joining today's Centers for Medicare and Medicaid Services conference call. This concludes your conference. You may now disconnect.

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